

**Section 1 - Patient/Provider Information** (Two matching unique patient identifiers on sample container and requisition are required for sample processing)

<b>PERSONAL HEALTH NUMBER</b> (or out-of province Health Number and province)		<b>ORDERING PRACTITIONER</b> Name and MSC#		<b>LABORATORY USE ONLY</b>
<b>PATIENT SURNAME</b>		Address of report delivery		
<b>PATIENT FIRST AND MIDDLE NAME</b>		<input type="checkbox"/> I do not require a copy of the report <input type="checkbox"/> I am a Locum <sup>†</sup> <sup>†</sup> If Locum, include name of Practitioner you are covering for		
<b>DOB</b> (DD/MMM/YYYY)	<b>SEX</b> M <input type="checkbox"/> F <input type="checkbox"/> X <input type="checkbox"/> U (Unk) <input type="checkbox"/>	<b>ADDITIONAL COPIES TO PRACTITIONER / CLINIC:</b> (Name, Address / MSC# / PHSA Client#) (Limit of 3 copies available)		
<b>PATIENT ADDRESS</b>				
<b>CITY</b>				
<b>PROVINCE</b>	<b>POSTAL CODE</b>	1.		
		2.		
		3.		
				<b>DATE RECEIVED</b>
				<b>OUTBREAK ID</b>
				<b>SAMPLE REF. NO.</b>
				<b>DATE COLLECTED</b> (DD/MMM/YYYY)
				<b>TIME COLLECTED</b> (HH:MM)

**Section 2 - Clinical Information**

<b>Reason for Test</b> <input type="checkbox"/> <b>NEEDLESTICK</b> <input type="checkbox"/> Outbreak/Cluster/Event <input type="checkbox"/> Prenatal <input type="checkbox"/> Other, specify: ..... .....		<b>Clinical Information</b> <input type="checkbox"/> Rash symptoms <input type="checkbox"/> STI contact <input type="checkbox"/> STI symptoms	
		<b>Recent Travel History</b> (Date/Location)	<b>Onset Date</b> (DD/MMM/YYYY)

**Section 3 - Test(s) Requested** (Note: Codes for PHSA Labs Use Only)

<p><b>PRENATAL SCREENING</b> (PRENAT)</p> <p>HIV <input type="checkbox"/> HIVCC          HIV Non-Nominal Reporting <input type="checkbox"/> HIVCC          HBsAg <input type="checkbox"/> HBVP          Rubella IgG <input type="checkbox"/> RUBEB          Syphilis Antibody (1st Trimester) <input type="checkbox"/> TPE          Other Tests, specify:          .....          .....</p> <p><b>PERINATAL SYPHILIS</b></p> <p>Perinatal (&gt;35 weeks/at delivery) <input type="checkbox"/> PDSYP</p> <p><b>SYPHILIS ANTIBODY</b></p> <p>Routine (Non Prenatal) <input type="checkbox"/> TPE</p> <p><b>HIV (Non Prenatal)</b></p> <p>HIV <input type="checkbox"/> HIVCC</p> <p><b>Note: Patient has the legal right to choose not to have their name reported to public health = non-nominal reporting</b></p> <p>Non-Nominal Reporting Requested <input type="checkbox"/> HIVCC</p>	<p><b>HEPATITIS SEROLOGY</b> (Serum)</p> <p><b>Acute - undefined etiology</b>          HBsAg, Anti-HBc Total, Anti-HBs, Anti-HCV, Anti-HAV IgM <input type="checkbox"/> HEPSB</p> <p><b>Chronic - undefined etiology</b>          HBsAg, Anti-HBc Total, Anti-HBs, Anti-HCV <input type="checkbox"/> DHEPCH</p> <p><b>Hepatitis B Screen Panel</b>          HBsAg, Anti-HBs, Anti-HBc Total <input type="checkbox"/> HBSAG</p> <p>Anti-hepatitis A Total (Immune Status) <input type="checkbox"/> HAAT</p> <p>Anti-hepatitis A IgM (Acute Infection) <input type="checkbox"/> HAVMB</p> <p>HBsAg Only <input type="checkbox"/> HBVSA</p> <p>Anti-HBs (Immune Status) <input type="checkbox"/> HBSAB</p> <p>HBeAg (Therapeutic Monitoring) <input type="checkbox"/> HBXE A</p> <p>Anti-HBe (Therapeutic Monitoring) <input type="checkbox"/> HBXE B</p> <p>Anti-HCV <input type="checkbox"/> HEPCB</p> <p><b>HEPATITIS C PCR</b> (EDTA Plasma)</p> <p>HCV RNA Quantitative (For diagnosis and monitoring) <input type="checkbox"/> HPCRBB</p> <p>HCV Genotyping (For treatment) <input type="checkbox"/> HEPCRB</p>	<p><b>OTHER SEROLOGY</b></p> <table border="0"> <tr> <th style="text-align: left;">Immunity</th> <th style="text-align: left;">Acute</th> </tr> <tr> <td>CMV IgG <input type="checkbox"/> CMVIGB</td> <td>CMV IgM <input type="checkbox"/> CMVSP</td> </tr> <tr> <td>EBV IgG <input type="checkbox"/> EBGSB</td> <td>EBV IgM <input type="checkbox"/> EBVSP</td> </tr> <tr> <td>Measles IgG (Rubeola) <input type="checkbox"/> MIGB</td> <td>Measles IgM (Rubeola) <input type="checkbox"/> MEASP</td> </tr> <tr> <td>Mumps IgG <input type="checkbox"/> MUIGB</td> <td>Mumps IgM <input type="checkbox"/> MUMPS</td> </tr> <tr> <td>Parvo B19 IgG <input type="checkbox"/> PARVGB</td> <td>Parvo B19 IgM <input type="checkbox"/> PARVP</td> </tr> <tr> <td>Rubella IgG <input type="checkbox"/> RUBEB</td> <td>Rubella IgM <input type="checkbox"/> RUBP</td> </tr> <tr> <td>Toxo IgG <input type="checkbox"/> TOXGSB</td> <td>Toxo IgM <input type="checkbox"/> TOXMSB</td> </tr> <tr> <td>Varicella IgG <input type="checkbox"/> VZIGB</td> <td></td> </tr> <tr> <td colspan="2"><hr/></td> </tr> <tr> <td><i>H. pylori</i> IgG <input type="checkbox"/> HELIB</td> <td>HSV Type Specific IgG <input type="checkbox"/> HSVTSS</td> </tr> <tr> <td>HTLV I / II <input type="checkbox"/> HTLVB</td> <td></td> </tr> </table> <p><b>OTHER TESTS (Specify)</b></p> <p style="background-color: #e0e0e0; padding: 5px;">For other available tests and sample collection information, consult the Public Health Laboratory's <i>eLab Handbook</i> at <a href="http://www.elabhandbook.info/PHSA/Default.aspx">www.elabhandbook.info/PHSA/Default.aspx</a></p> <p style="font-size: small;">The personal information collected on this form is collected under the authority of the Personal Information Protection Act. The personal information is used to provide medical services requested on this requisition. The information collected is used for quality assurance management and disclosed to healthcare practitioners involved in providing care or when required by law. Personal information is protected from unauthorized use and disclosure in accordance with the Personal Information Protection Act and when applicable the Freedom of Information and Protection of Privacy Act and may be used and disclosed only as provided by those Acts.</p>	Immunity	Acute	CMV IgG <input type="checkbox"/> CMVIGB	CMV IgM <input type="checkbox"/> CMVSP	EBV IgG <input type="checkbox"/> EBGSB	EBV IgM <input type="checkbox"/> EBVSP	Measles IgG (Rubeola) <input type="checkbox"/> MIGB	Measles IgM (Rubeola) <input type="checkbox"/> MEASP	Mumps IgG <input type="checkbox"/> MUIGB	Mumps IgM <input type="checkbox"/> MUMPS	Parvo B19 IgG <input type="checkbox"/> PARVGB	Parvo B19 IgM <input type="checkbox"/> PARVP	Rubella IgG <input type="checkbox"/> RUBEB	Rubella IgM <input type="checkbox"/> RUBP	Toxo IgG <input type="checkbox"/> TOXGSB	Toxo IgM <input type="checkbox"/> TOXMSB	Varicella IgG <input type="checkbox"/> VZIGB		<hr/>		<i>H. pylori</i> IgG <input type="checkbox"/> HELIB	HSV Type Specific IgG <input type="checkbox"/> HSVTSS	HTLV I / II <input type="checkbox"/> HTLVB	
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### 1 - Patient/Provider Information

For physicians who work at more than one location, please provide an address for delivery.

#### - Additional Copies To

The Ordering Physician will receive one copy of the report. Each physician or client listed under Additional Copies To: will receive a copy of the report.

### 2 - Clinical Information

Please fill in as completely as possible.

**Public Health Laboratory**  
655 West 12th Avenue, Vancouver, BC V5Z 4R4  
www.bccdc.ca/publichealthlab

**Serology Screening Requisition**

**Section 1 - Patient/Provider Information** (Two matching unique patient identifiers on sample container and requisition are required for sample processing)

PERSONAL HEALTH NUMBER (or out-of-province health number and province) **1**

PATIENT SURNAME **1**

PATIENT FIRST AND MIDDLE NAME **1**

DOB (DD/MM/YYYY) SEX  M  F  X  U (unk)

PATIENT ADDRESS **1**

CITY **1**

PROVINCE **1** POSTAL CODE **1**

ORDERING PRACTITIONER (Name and MDC) **1**

Address of report delivery **1**

I do not require a copy of the report  I am a Locum!  
If Locum, include name of Practitioner you are covering for

ADDITIONAL COPIES TO PRACTITIONER / CLINIC: (Name, Address / MDC/PHSA Client) (Limit of 3 copies available)

DATE RECEIVED

LABORATORY USE ONLY

OUTBREAK ID

SAMPLE REF. NO.

DATE COLLECTED (DD/MM/YYYY)

TIME COLLECTED (PHSA)

**Section 2 - Clinical Information** **2**

Reason for Test  NEEDLESTICK  Outbreak/Cluster/Event  Rash symptoms  STI contact  STI symptoms

Prenatal  Other, specify: \_\_\_\_\_

Recent Travel History (Date/Location)

Onset Date (DD/MM/YYYY)

**Section 3 - Test(s) Requested** (Note: Codes for PHSA Labs Use Only)

PRENATAL SCREENING (PRENAT)	HEPATITIS SEROLOGY (Serum)	OTHER SEROLOGY
HIV <input type="checkbox"/> HIVCC	Acute - undefined etiology HBsAg, Anti-HBc Total, Anti-HBc, Anti-HCV, Anti-HAV IgM <input type="checkbox"/> HEP5B	Immunity Acute
HIV Non-Nominal Reporting <input type="checkbox"/> HIVCC	Chronic - undefined etiology HBsAg, Anti-HBc Total, Anti-HBc, Anti-HCV <input type="checkbox"/> DHEPCH	CMV IgG <input type="checkbox"/> CMVGB <input type="checkbox"/> CMV IgM <input type="checkbox"/> CMVSP
HBsAg <input type="checkbox"/> HBVP	Hepatitis B Screen HBsAg, Anti-HBc, Anti-HBc Total <input type="checkbox"/> HBSAG <input type="checkbox"/> HBSAB	EBV IgG <input type="checkbox"/> EBVGB <input type="checkbox"/> EBV IgM <input type="checkbox"/> EBVSP
Rubella IgG <input type="checkbox"/> RUBEB	Anti-hepatitis A Tox (Immune Status) <input type="checkbox"/> HAAT	Measles IgG (Rubella) <input type="checkbox"/> MIEG <input type="checkbox"/> Measles-IgM (Rubella) <input type="checkbox"/> MEASP
Syphilis Antibody (1st Trimester) <input type="checkbox"/> TPE	Anti-hepatitis A IgM (Acute Infection) <input type="checkbox"/> HAAMB	Mumps IgG <input type="checkbox"/> MUIEG <input type="checkbox"/> Mumps IgM <input type="checkbox"/> MUMPS
Other Tests, specify: _____	Anti-hepatitis B Tox (Immune Status) <input type="checkbox"/> HBAT	Parvo B19 IgG <input type="checkbox"/> PARVGB <input type="checkbox"/> Parvo B19 IgM <input type="checkbox"/> PARVPM
<b>PERINATAL SYPHILIS</b> <b>4</b>	Anti-hepatitis B IgM (Acute Infection) <input type="checkbox"/> HBAMB	Rubella IgG <input type="checkbox"/> RUBEB <input type="checkbox"/> Rubella IgM <input type="checkbox"/> RUBPM
Perinatal (>35 weeks) <input type="checkbox"/> PDSP	HBsAg Only <input type="checkbox"/> HBVSA	Toxo IgG <input type="checkbox"/> TOXG5B <input type="checkbox"/> Toxo IgM <input type="checkbox"/> TOXIM5B
<b>SYPHILIS ANTIBODY</b>	Anti-HBs (Immune Status) <input type="checkbox"/> HBASA	Vaaccella IgG <input type="checkbox"/> VZIGB
Routine (Non Prenatal) <input type="checkbox"/> TPE	HBeAg (Therapeutic Monitoring) <input type="checkbox"/> HBXEA	<i>M. pylori</i> IgG <input type="checkbox"/> HELIB <input type="checkbox"/> HSV Type Specific IgG <input type="checkbox"/> HSVTSS
<b>HIV (Non Prenatal)</b> <b>5</b>	Anti-HBe (Therapeutic Monitoring) <input type="checkbox"/> HBXEB	HTLV I / II <input type="checkbox"/> HTLVI
HIV <input type="checkbox"/> HIVCC	Anti-HCV <input type="checkbox"/> HEP5CB	<b>OTHER TESTS (Specify)</b> <b>9</b>
Note: Patient has legal right to choose not to have their name reported to public health - non-nominal reporting	<b>HEPATITIS C PCR</b> <b>8</b>	For other available tests and sample collection information, consult the Public Health Laboratory's eLab Handbook at: <a href="http://www.eLabHandbook.info/PHSA/Default.aspx">www.eLabHandbook.info/PHSA/Default.aspx</a>
Non-Nominal Reporting Requested <input type="checkbox"/> HIVCC	HCV RNA Quantitative (For diagnosis and monitoring) <input type="checkbox"/> HPCR5B	The personal information collected on this form is collected under the authority of the Personal Information Protection Act. The personal information is used to provide medical services requested on this requisition. The information collected is used for quality assurance management and disclosed to healthcare practitioners involved in providing care or when required by law. Personal information is protected from unauthorized use and disclosure in accordance with the Personal Information Protection Act and when applicable the Freedom of Information and Protection of Privacy Act and may be used and disclosed only as provided by those Acts.
	HCV Genotyping (for treatment) <input type="checkbox"/> HPCR5B	

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### 3 - Prenatal Testing\*

- If nominal HIV testing, please provide 2 serum separator tubes.
- If non-nominal HIV testing, please provide 3 serum separator tubes.

### 4 - Perinatal Testing (Syphilis only)

- Please provide 1 serum separator tube.

### 5 - HIV Testing\*

- If nominal HIV testing, please provide 1 serum separator tube.
- If non-nominal HIV testing, please provide 2 serum separator tubes.

### 6 - Hepatitis Serology Testing

- Please provide 1 serum separator tube.

### 7 - Combinations of Syphilis, nominal HIV, Hepatitis Serology and Other Serology

- Please provide 1 serum separator tube.
- If non-nominal reporting for HIV\* is requested, please provide an additional serum separator tube (2 tubes in total).

### 8 - Hepatitis C PCR Testing

- For HCV RNA and HCV genotyping requests, please provide 1 EDTA plasma (lavender-top) tube.

### 9 - Other Tests

- Indicate all additional tests requested. Please consult the PHSA Laboratories [eLab Handbook](#) for specimen requirements.

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\*Note for HIV patient has the legal right to choose not to have their name reported to public health.